PART I

1

Preparing for Multi-professional Practice

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By reading this chapter you should be able to:

- **define what is meant by multi-professional practice**
- **identify the drivers towards multi-professional practice**
- **describe how people work together**
- **present barriers to multi-professional working and how they may be overcome**
- **reflect on your experience of multi-professional working at this stage in your practice**
- **access websites to learn more about models of multi-professional working and new professional roles.**

Introduction

Working with other professionals is part of everyday practice in health and social care. Multi-professional collaboration and team work have been presented as positive and necessary practice interventions, to achieve good care provision by successive governments for several decades.

This endorsement can be viewed in a number of ways. At one level, politicians have been responding to outcomes of major inquiries into child abuse, where all too often relationships and communication strategy between professionals and agencies have been criticised (Laming, 2003). From a different perspective responses are focussed around a need to provide a more holistic and person-centred approach to care provision from service providers. Founded in the move from institutional models of care to community based services that has taken place is a desire to cut down the need for

service users and their families to be constantly assessed and in contact with a huge quantity of different professionals. It takes into account both the need for a person centred approach to practice and the need to maximise the use of resources in service delivery.

While it would be difficult to argue with these aims, and successive governments and national bodies have attempted to achieve them, there is evidence that working with other professionals has not always been straightforward or effective. This does not mean good multi-professional practice does not take place, rather that it can be a more complex process than we might expect.

In order to help you make sense of the challenges faced, this chapter will begin by examining what is meant by multi-professional practice. Traditional and more radical models of multi-professional practice will be defined; while key characteristics of it – such as team working and team work activity – will be reviewed. The perspectives of researchers and professionals from a range of health and social care disciplines will be presented. As part of this process the chapter will explore why people work together, and offer examples of the legislative frameworks and policy drivers that have influenced developments. Having established *why* people work together, you will be guided to consider *how* people work together, and the forms of teamwork roles they may use. The chapter study activity will support you through the content presented here and, throughout, you will be encouraged to reflect on what is needed to make multi-professional practice work.

Towards a definition of multi-professional practice

A number of terms have been used to describe professionals working together. You may be familiar with the following: multi-professional, multi-disciplinary, multi-agency, inter-professional, inter-agency, collaboration and partnership working. Leathard (1994: 5) describes the 'terminological quagmire' created as developments in practice have accelerated. In her analysis of terms, Leathard (1994: 6) suggests that for some professionals the use of inter-professional is not adequate as it applies to only two professional groups working together, whereas multi-professional infers a wider group. Pollard et al. (2005: 10 cited in McCray, 2007) define multi-professional practice as practice between different professional groups but not necessarily including collaboration. This means that professional groups may agree with a family or patient on an intervention, but each professional group will work separately to provide the care agreed. Carrier and Kendall (1995: 10) suggest that inter-professional work may be more conducive to working across boundaries to meet client needs.

You may have noted in health care practice settings the use of the term multidisciplinary team, used as an alternative term to multi- or inter-professional practice. Leathard notes (1994: 6) that it is usually used to describe a team of individuals from different professional backgrounds 'who share common objectives but who make a different but complementary contribution to practice' (Leathard, 1994: 6). Sheehan, Robertson and Ormond (2007: 18) cite Paul and Peterson (2001) and offer three distinctive teamwork

approaches in health care. These are multidisciplinary, where interaction and communication across teams tends to be informal as in Leathard's (1994: 6) definition; Interdisciplinary, where the roles of professionals overlap and communication is formal and informal for the good of the patient; and transdisciplinary, where there is greater overlap, blending and blurring of professional roles. Transdisciplinary team work is the least common approach currently in place in the NHS in the UK.

In social care settings, for example in family social work teams, the term multi-agency may be used. This term describes multi-professional practice in teams with the involvement of a range of services such as education, housing and health, and professionals including social workers, nurses, teachers and housing workers, all involved in providing services for an individual (McCray, 2006). Increasingly, the service user and carer and their representative will also be a part of this multi-agency work and this may be called partnership working. Changes in how services are delivered set out in policy documents by government are often the key driver for these types of activity, although good informal practice may also be in place. Three models of multi-agency working are offered in the every child matters guidance (DFES, 2006 accessed at www.ecm.gov.uk/multiagencyworking)

First, a multi-agency panel in which:

- Practitioners remain employed by their home agency.
- They meet as a panel or network on a regular basis to discuss children with additional needs who would benefit from multi-agency input.
- In some panels, case work is carried out by panel members. Other panels take a more strategic role, employing key workers to lead on case work. This might be viewed as multi-professional working.

Second, a multi-agency team where:

- There is a more formal configuration than a panel, with practitioners seconded or recruited into the team.
- The team has a leader and works to a common purpose and common goals.
- Practitioners may maintain links with their home agencies through supervision and training.

These are in place in Youth Offending teams in children's services and are an example of interprofessional working.

Finally, an integrated service which would include:

- A range of separate services that share a common location, and work together in a collaborative way.
- A visible service hub for the community.
- A management structure that facilitates integrated working.

This type of working is the most radical in terms of working across professional boundaries and is closer to the transdisciplinary team working model described above, with an emphasis on formal collaboration.

Collaboration in the form of partnership working across organisations or agencies in health or social care may be an element of multi-professional and multi-agency activity. This consists of a formal arrangement within which collaboration and collaborative practice are agreed through contractual agreements. Other less formal models may be in place. Collaborative working can be defined as:

> A respect for other professionals and service users and their skills and from this starting point, an agreed sharing of authority, responsibility and resources for specific outcomes or actions, gained through cooperation and consensus. (McCray, 2007a: 132)

So let us now return to our starting aim, which was to define multi-professional working. Your reading so far has shown that there are a number of terms used in practice by professionals to describe multi-professional working often to mean the same thing. You have read that a number of academics have explored the reasons for this. To help you use this book effectively, the term multi-professional will be used by all chapter writers, because:

- it is used most predominantly and commonly in the literature and by professionals in practice across the NHS and broader practice contexts in the same way.
- the most important elements of multi-professional practice activity are collaboration and teamwork, which are at the centre of service provision and good care and which will be the key focus of your reading and activity throughout this book.

Now let's consider the design of service delivery models in place in practice settings. There are varying degrees of multi-professional collaboration taking place depending on the sort of care and support being delivered to whom, and the types of team in place. Reviewing the impetus and purpose behind these models of service delivery will enable you to understand further the nature of multi-professional working and help you answer the question 'Why do people work together?'

Why people work together: drivers for multi-professional practice

Ultimately, changes in the way funding of services is allocated by government in order to make their policies happen, means services must develop new ways of working with other professionals to continue to maintain funding. This is a significant factor in the shift towards multi-professional working. There are a number of reasons for this, which are discussed below.

Protecting vulnerable people

The need to ensure a more effective safety net for protection of vulnerable people in society in the light of public responses to child abuse cases. For example, the need for

policy makers to address the recommendations of public enquiries where key failures had occurred around professional accountability and communication, as in the case of Victoria Climbie (Laming, 2003). This has led to a radical review and a radical transformation of professional practice in children's services. Every Child Matters (DFES, 2004) made recommendations about children's services which were formally built on the Children Act (DFES, 2004), setting out five core outcomes for children. These outcomes are charged to the local authority who must meet the requirements of section 10 of the Children Act, to secure collaboration 'through the creation of a single children's and young people plan (CYPP), leading to the creation of children's trust' (DFES, 2005). The breadth of these outcomes means a multi-agency approach is needed, and multi-professional practice will be at the centre of ensuring changes are made to services so that these outcomes can be met and funding streams follow.

Changes to models of service delivery based on ideological issues

These can be seen in the move from institutional to community-based services for service users with mental health or learning disabilities, culminating in a need for different working relationships among professionals and with service users and carers. In mental health services, community provision has meant that some individuals with severe mental illness living in the community may be at increased risk of physical health problems, as they are reliant on attending primary care services which may not always be most accessible for this group of people. The document Choosing Health: Supporting the Physical Needs of People with Severe Mental Illness – Commissioning Framework (DoH, 2006d), sets out the core issues involved in improving provision and subsequently care. Advocating a nurse-led assessment service are a number of multi-agency and multi-professional relationships required to improve services. The introduction and further development of individual budgets for service users in social care will increase the collaborative and partnership element of multi-professional practice as the service user drives the delivery and design of his or her needs.

Transformation of acute health care delivery created by technological change

The massive technological changes in operating practice in acute medicine such as key-hole surgery, and evidence-based management of postoperative conditions has made the patient journey through secondary health care a much shorter one. Patients can be discharged rapidly following intervention that can aid recovery time and ensure maximum bed occupation in acute care wards. Such changing practice means the patient and his or her family has a greater reliance on the primary care team post operatively. Multi-professional relationships between secondary and primary care health services are crucial, as are those within the primary care health team, post discharge.

Transition of management of people with long term chronic conditions to the community

A move towards community-based support for patients with long term chronic conditions has taken place with support provided though community-based nursing teams in liaison with GP practices. The management of these processes from referral to assessment through to ongoing management is usually led by community nursing teams with a centrally led administrative function. A number of multi-professional networks are needed for this service to work effectively involving primary and secondary health care services, social care agencies and the independent sector.

The changing role of the voluntary and independent sectors

As care of elderly people has moved to the community, local authorities are increasingly working in formal partnerships with a third sector service that will be commissioned to deliver social care support to older people living at home or in residential care. Additionally, primary care trusts in health care may work in partnership with a third sector hospice, commissioning them to provide day-care for people requiring palliative care. Frequently, service users groups and their representatives are integral members of these formal partnerships and teams involved in the planning and design of packages of care. Professionals working in teams within these partnership agreements have both a formal and informal working relationship on which to deliver multi-professional practice. Commissioning arrangements may be very challenging, due to expectations of high quality delivery of service despite tight resources.

Guided Study 1.1

Think about a recent day in practice and the experience of a patient or service user you met.

Ask yourself:

- Is this patient's experience likely to have changed in recent times?
- What would have created this change?
- Do these changes bring about different roles for professionals?
- Has the role of the nurse changed?
- What multi-professional roles and relationships might be created?

The section above should help you to answer the question in Guided Study 1.1 and, from your reading here and practice experience, you will have seen that service delivery models are influenced by a number of factors. Multi-professional practice can occur in a number of ways and to a number of levels. Traditional and emerging ways of working

may be in place involving professionals in health care, health and social care, and increasingly education, health and social care. The pace of change is unprecedented. Narrow definitions of primary care and of team working can no longer be regarded as the norm as complex care and intervention takes place within community settings, and social care is undergoing radical transformation.

In forthcoming chapters you will read and consider case study-based examples of these changes in practice. First we continue to discuss these newly developing models of service in order to answer the question 'How do people work together?'

How people work together

Most multi-professional work takes place in a team work setting. Mickan and Roger (2000: 201) define a team as a small number of members with appropriate skills to complete a specific task, with agreed performance goals and collective responsibility for achieving them. However, there are many levels and types of multi-professional team working and collaboration with increasingly innovative models of practice.

Much of the research into multi-professional practice has taken place in health care Odegard (2007: 46) cites Barr, et al. (2005) and Doherty (1995) who observes that multi-professional collaboration may involve several health care levels, including with organisations, service users, carers and communities as well as professionals. Doherty (1995) explores the scale of collaboration among professionals in health care, from level 1 minimum – professionals based in separate places and separate case loads through to level 5 – where all professionals are fully integrated, share offices, cases and totally understand each others' professional roles and values. At level 5 the team and its functioning is important, as are patient issues. In Doherty's research most professionals were collaborating at level 3, sharing the same systems and meeting face to face to discuss patients and their care. However, new models of practice–such as integrated teams in adult care services–mean that level 5 collaboration is becoming more frequent. An evaluation by Hudson (2007: 8) of the Sedgefield integrated team, from 2004 to mid 2006, describes the development of five locality based teams. These new teams incorporated three partners, the primary health care trust, borough councils for housing and the county council for social care services. Service models were created which were both locally based and with integrated teams at level 5 in terms of collaboration. Hudson, in his analysis of the Sedgefield evaluation findings (2007: 4), presents two models of teamwork based on a review of the literature, each holding two distinct sets of characteristics. These models are identified as the *pessimistic* and *optimistic* models. The pessimistic model (Hudson, 2007: 4) includes a distinctiveness of trait, knowledge, power, accountability and culture, in contrast to the optimistic model, where team members share a commonality of values, accountability, learning, location, culture and case.

In reviewing these two models, the terms *traditional* and *contemporary* might also be appropriate to describe the different positions of professions within teams. Traditional team working in the pessimistic model may be straitjacketed by barriers that professionals holding distinctive trait, knowledge, status, power, accountability and culture created. Yet contemporary or optimistic model characteristics suggest that, as Hudson notes, 'features that professions have in common may outweigh factors that divide them' (Hudson, 2007: 5).

In answering the question: 'How do people work together', it is worth exploring Hudson's research more fully. First, in relation to values, McCray (2006: 254) describes personal values as 'something that individuals hold at the centre of their being. Values are developed over time and from experience, and personal values may reflect an individual's culture, moral stance or lifestyle'. Hudson (2007: 5) suggests that team working offers the opportunity to share values based on a belief in universalism; that is, services for all and benevolence in service delivery. In terms of influencing how people work together, values may be very significant, as shared beliefs might be a huge motivator for collaboration, overcoming the differences created by professional traits, knowledge, status and power for the good of the patient or service user. Such differences may be created by the set of behaviors, authority, separate and specialised knowledge (Hudson, 2007: 5) that have been developed historically by some professions and which may contribute to a monopoly of views and practice specialisms that ensure maintenance of the profession as paramount.

Second, in relation to the commonality of case, Hudson citing Guy (1986) writes that as patient or service user need becomes more complex, there is a greater urgency to involve a range of professionals, which we discussed earlier in relation to changes to children's services. Such changes mean that joint responsibility for cases means there is less room for individual professional contribution and more support for multi-professional collaboration.

Hudson also notes in his review that a shared location may also be a key factor in how people work together as team members. Thus leading to socialisation to a team, rather than to a separate profession.

Summarising, Hudson (2007: 14) notes that there is much to be gained from the optimist model, particularly among some professional groups. Key factors identified in his study and highlighted here can assist in the further development and integration of teams and impact on service user outcomes and safety. They can also help us to address the question of how professionals work together as we continue to explore professional roles in teams.

Guided Study 1.2

From your reading so far, what factors may make a difference to how people work together?

You could have included:

- Shared values and shared beliefs about service delivery
- Shared responsibility and accountability for care
- Meeting face to face to discuss cases
- Shared environment.

Roles in teams

By exploring team roles, we can look at research from two positions; the team leadership role and the team player role. Let's start with leadership.

Leadership

Our opening study, by Hean et al. (2006: 161), involves health and social care students entering university. Ten professional groups rated each other on a number of characteristics which could have an impact on future team roles. One of the main purposes of the research was to investigate the impact of previously held stereotypes on perceptions of professional group characteristics. The findings are of interest when we start to think about team roles in practice. For example midwives, nurses and social workers were rated highest on interpersonal characteristics and doctors and pharmacists lowest, which was also the case when being a team player was rated.

When leadership was scored doctors were most highly rated with midwives and social workers also viewed highly. Hean et al. (2006: 177) note an assumption that is made that fits with other studies and with their own perception identified by Freeman et al. (2000) below, that doctors are natural leaders.

The authors of this research with undergraduate professionals write that it will be interesting to note if these views remain after the students have participated in a shared multi-professional education experience or into practice on qualification. Equally, such views are debated in terms of the challenge facing some professional groups – such as nurses – who are required and are often best placed to take on leadership roles in team settings.

Moving onward to qualified professionals, Sheehan et al. (2007: 18) cite Freeman et al. (2000), who define a number of teamwork philosophies or characteristics held by teamwork members in health care. These individual perspectives show the range of different views of teamwork roles held by professionals. In their study, doctors saw themselves as having a directive role: seeing themselves as leaders of teams. Social workers, nurses and therapists viewed their role as collaborators and team players and Freeman et al. described this role as integrative (2000). A further perspective was that of the elective team member: someone who was largely autonomous with limited contact with other team members, for instance mental health workers.

It would seem that roles established early are maintained into practice in healthcare in a number of teamwork settings. What's more, in acute clinical practice, many traditional teams of clinicians are hierarchial. Bleakley et al. (2006: 468) studied team roles in operating theatres, where they observed that technical expertise determined leadership and decision making processes, even though when mistakes were made it was usually due to communication or other non technical skills.

Sheehan et al. (2007: 19) caution against always assuming that doctors dominate team decisions and take on the leadership role. They cite Unsworth et al.'s (1997) study in a rehabilitation setting, where occupational therapists were as significant in decision making as doctors. Moreover Gair and Hartery (2001, cited by Sheehan et al., 2007: 19) write that doctors were more likely to have their proposals questioned than any other professional group and were willing to concede and accept alternative decisions. Recent changes to qualifying education (DoH, 2004c) means that doctors will be focussing on their leadership and management development as well as clinical skills from foundation placement after medical school (www.mmc.nhs.uk/pages/specialities/specialityframework), which may change the way in which they negotiate and work with others in teams.

In health care services we can see some interesting research findings and educational responses to multi-professional roles, notably about perception in terms of who should lead teams and what the basis for these views is. Hean et al. (2006: 178), when discussing their findings, see early perceptions of professional roles as both potentially harmonious and a source of conflict in teamwork, if expectations of other professionals are not met. A range of other factors can also influence leadership roles, such as organisational structures which might make team working very formal, and the type and duration of the teamwork activity underway. For example, if you have worked in an acute hospital ward you will know that some practice processes – such as the assessment of older people – may be very complex and linked to a set of procedures which work on a step to step basis. As steps are in effect 'ticked off' and the patient is moved through the system there is little room for multi-professional contributions (Huby et al., 2007), which could be viewed as a result of a hierchial medical leadership model. In reality it's the process of assessment itself that creates the lack of participation.

In work across health and social care it is possible that change may be more challenging if ideas about professional roles are very deeply held, especially when it comes to team leadership. New models of young people's services mean that some managers in social care are now leading health care professionals in drug crisis teams. This should bring extra opportunities for face to face multi-professional communication and information sharing to enhance good practice, yet a common concern of social care managers is the medical model of practice these professionals will bring to the team. If we return to Hean et al.'s research (2006: 161), the origin of views about professional practice of health care professionals came from very early professional experiences. Assumptions made about professional roles and the dangers of seeing uniform values within any one professional group and professional culture may create unnecessary barriers and inhibit multi-professional collaboration and change.

Guided Study 1.3

Return to a recent practice experience and a patient or service user you met.

- Where were they receiving care of support and which professionals were giving it?
- What agency did the professionals work for?
- How many professionals seemed to be involved?
- Who was leading the care and support and why do you think this was the case?
- What agency was funding the care and support?
- What role did the nurse have?

Need to know more

In completing the activity where you able to answer all sections? Do you need more information about practice? If so make a note of areas you need to explore further, on your next day in practice.

Being a team player

Earlier in the chapter, Freeman et al. described the collaborative role in multi-professional practice as integrative (2000), meaning having a purposeful role in how the team works.

This role is often the domain of nurses and therapists in health care. A team player role is significant because those professionals who take it on have a commitment to the team function and its processes. This means their focus on communicating with their team members as part of meeting team objectives and providing feedback after and during intervention keeps the team together and ensures the meeting of client or service user need.

Research shows us that other professionals also invest in the team player role. In children's services, Odegard's Norwegian study (2007: 52) measured time spent on collaboration by professionals in a child mental health team. The researchers asked nine professional groups including teachers, nurses, social workers and psychologists, to measure how much time they spent on collaboration within their own organisation and outside it, in a working day. Odegard found that all professionals studied stated they spent on average 40 per cent of their time collaborating with others in their own organisation about the children's needs, while social workers spent the most time collaborating both internally and externally.

Mickan and Rodgers' study (2005: 358) explored the characteristics of effective teams in health care. The importance of team cohesion was noted by participants in the study and the camaraderie and involvement that was generated in team working created commitment to the team and other members (2005: 366), resulting in a number of positive aspects for practice.

Some roles in practice formally merge leadership and team player roles, as teams and networks cross from secondary care to primary care and health and social care in the community. An example of this is the community matron. Community matrons work in multi-professional, multi-agency settings. They therefore need a high level of communication, problem-solving and decision-making skills as well as advanced clinical skills. They must be able to manage risk appropriately, and to take responsibility for leading complex care coordination, professional practice and leadership, underpinned by multi-agency and partnership working. In social care, a children's centre manager – for example in a Surestart project – will also combine leadership and team player roles working with local communities to determine priorities for children from an early age, as well as working with other professionals and partners to meet strategic performance objectives in relation to the educational, social and health care needs of children.

Guided Study 1.4

The role of the community matron and a children's centre manager are set out above. What sort of service users, carers and professionals might they work with? What multi-professional knowledge and skills will they require to undertake this role?

Need to know more?

In completing the activity, were you able to answer all of the questions? Do you need more information about these roles in practice? If you do, make a note of the areas you need to explore further on your next day in practice.

Box 1.1 The following websites will help you

For Children's Centre Managers: www.surestart.gov.uk/research/
For Community Matrons: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4133997
www.nmc-uk.org.uk a website to encourage joint working in children's services

The roles of community matron and children's centre manager merge multi-professional leadership and team player skills and knowledge. Yet their roles could not be effective if the views of service users and communities were not seen as essential in decision making and planning about service delivery and forms of practice intervention.

Service user involvement

Attempting to describe one model of meaningful service user involvement in multi-professional practice is just not possible. Beresford (2005: 8) cites his earlier work with Croft (Beresford and Croft, 1996) to offer the two most widely used interpretations. First, the managerialist approach, which focuses on getting service users to inform service design and provision. Second is the democratic approach, may be service user-led and attempts to give more control to service users over the services they use and how they use them. The democratic approach is more concerned with gaining power for service users, while the managerialist approach is more about information gathering.

In terms of multi-professional practice and collaboration, it is likely that service users will be involved in both managerialist and democratic roles in teamwork. Service user groups will be consulted or co-opted to teams to plan and evaluate service changes in primary care, fulfilling a largely managerialist agenda. Equally, a multi-professional team may seek the individual view of a young person who is a service user on the type of foster care he or she would like, which should be a more democratic model of participation.

As a nurse you will be aware that people's state of physical and emotional health could impact on their level of participation in decision making about their care. Likewise in social care, in child protection cases some families are unlikely to willingly participate in decisions that may involve taking their children into care. Other service users may not seem able to communicate their wishes, for example people with learning disability or older people who have cognitive impairment.

This does not mean that the individual's views need not be explored in team decision making, but that you should be aware of how some systems in health and social care prevent participation from being as effective as it could be. If you revisit Huby et al.'s (2007: 64) research about discharge planning in older peoples services, you will see that they

note that the very specific criteria used to tick off stages in discharge which prevented multi-professional collaboration also inhibited patient participation. They note that simple changes to the planning process could make a difference.

In multi-professional working, good practice should include a discussion about the nature of the role of the service user in the team decision making process. Does the team see the contribution of individual service users to activity as holding more, less or equal value than professional input? Are their difficulties in involving the service user patient or carer and how could these be overcome? Is the team making assumptions about what people might choose? From an open debate real collaboration and practice to create change or challenge current systems can take place.

Developing your knowledge, skills and values

You can see from the research that multi-professional working takes place because of several drivers. People work together in teams in differing roles to meet key objectives. A number of positive characteristics for teams have been identified. As you have read the chapter content and worked through the guided study exercises you will be gaining or building on your knowledge of multi-professional working. You have identified key skills, knowledge and values to make multi-professional practice work.

Guided Study 1.5

Make a note of the positive characteristics, key skills and knowledge required for multi-professional practice below.

You could have included:

- Sharing values and beliefs about service delivery
- Sharing responsibility and accountability for care
- Meeting face to face to discuss cases
- Sharing a working environment
- Working with a team to engage service users in a meaningful way
- Avoiding common perceptions of other professional groups and their role in teams
- Making collaboration a major part of your working day
- Building strong team relationships and strong links with the community and or other services
- Communicating with team members about meeting team goals
- Learning about other professional roles
- Being aware of some practice processes such as discharge planning that may inhibit multi-professional team working and patient or service user involvement
- Leadership skills.

Conclusion

This chapter has introduced you to the concept of multi-professional practice, where the motivators for its use have come from, and how and why people work together.

By concentrating on what is needed for good practice you have been guided to identify some barriers to multi-professional working, which can make practice ineffective. You will know that by not addressing gaps in your knowledge, skills and values and any strongly held misconceptions of other professionals, service users and their roles, you may not be as well equipped as you could be for twenty-first century practice. The forthcoming chapters will explore these themes further, linking to specific aspects and models of service delivery and helping you to increase your knowledge and identify skills to use to develop your practice.